Medwork Independent Review
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MEDWORK INDEPENDENT REVIEW WC DECISION

DATE OF REVIEW: 10/28/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Work hardening program - 10 sessions of physical therapy.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Texas State Licensed MD Board Orthopedic Surgeon

REVIEW OUTCOME
Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:
☒ Upheld (Agree)
☐ Overturned (Disagree)
☐ Partially Overturned (Agree in part/Disagree in part)
Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY:
The female was reportedly injured when she fell XX/XX/XX. The patient underwent medical and then surgical treatment for a left shoulder rotator cuff tear. The claimant reportedly underwent surgical intervention initially in xxxx and that included arthroscopy with cuff repair revision. Prior to that however, in xxxxx, the claimant underwent left shoulder arthroscopic subacromial decompression and debridement.

Subsequently, the claimant was noted to have persistent pain in the affected left shoulder. There was also reported weakness in the shoulder along with paresthesias into the left arm and into the hand. She was reportedly unable to make a fist with the left hand. The treatments had included therapy and medications. There was noted to have been a functional capacity evaluation from xxxx. Within that evaluation, there was noted to be multiple areas that were felt to be invalid, in fact 5/5 categories tested. The physical demand classification was noted overall to be a light PDC. The records further reveal that the claimant was noted as of xxxxx, to report pain in the shoulder with moderate decreased range of motion along with tenderness of the shoulder. A positive impingement sign was also noted. It was noted to be moderate decrease overall in strength in addition to motion.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

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Diagnosis included that of adhesive capsulitis rationale. The claimant, despite the most recent findings evidencing persistent pain and weakness and stiffness in the shoulder and objective findings reportedly corroborating same, has been noted in a functional capacity evaluation to have 5/5 categories, of which there were invalid findings documented. The claimant had been noted in that same functional capacity evaluation that the individual was felt to be capable of performing the essential functions of the physicians thought and did not have any particular conditions or abnormalities overall. The home consideration therefore for a work hardening program does not appear to need guidelines for the same guidelines would not support such work hardening at this time as they specifically reveal that results "should indicate consistency with maximal effort and demonstrate capacities below an employer verified physical demands analysis, but the inconsistencies and/or indication that the patient had performed below maximal effort should be addressed prior to treatment in these programs". Therefore, the referenced ODG guideline criteria for work hardening has not been met comprehensively and the considered work hardening does not appear to be supported by comparing the records, reviewed with the applicable clinical guidelines.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**